NOTARIZED AUTHORIZATION FOR REALESE OF RECORDS
AGENCY FOR WORKFORCE INNOVATION
UC Benefits Records, Po Box 5750, Tallahassee, Florida 32314-5750
Telephone: (850) 921-3470 Fax: (850) 921-3912

This authorization is for a release of confidential information contained in the Agency for Workforce Innovation

SECTION I

☐ I applied for Florida UC benefits within the past year and have completed Section II and provided my signature in Section IV
☐ I am requesting information from your records pertaining in the individual identified in SECTION II who has authorized the release of this information to me through signature and attestation of identity required by SECTION IV below.

The Information I am requesting is:

☐ Claim documents √ Computer printout of benefits payments √ Computer printout of current wage history
☐ Other (Please specify) _____

SECTION II

Name _____Social Security Number_____
Address_____/_____
City: _____State: _____Zip Code_____ Date of Birth: _____
(MM/DD/YY)

Telephone: _____

SECTION III

I authorize the Agency of Workforce Innovation to release the records requested in its possession pertaining to (Check one)☐ me or☐ the individual indicated below. I understand the information may include records the reveal my identity, the amount of UC benefits received, medical records, or other evaluation including any drug test information, and/or the identity of employment units for which I have. If requested, the information may include the identity of the employing unit to which I was referred for employment.

If this request involves a court case, please provide the following:

I further authorize the agency for Workforce Innovation and any of its employees to appear and provide oral testimony regarding my records and other information requested by subpoena, in any deposition, hearing or other proceeding relevant to:

Case Style: _____Case number: _____
Which is now pending in jurisdiction? _____
(Identify court/administrative body). This authorization is valid until the above style case in concluded.

The information requested is to be provided to a party other than indicated in SECTION II; please forward the information in to:

SEMINOLE COUNTY COMMUNITY ASSISTANCE
ATTN: ***EMERGENCY FINANCIAL ASSISTANCE***
534 West Lake Mary Boulevard
Sanford, FL 32773
Tel: 407-665-2300 Fax: 407-665-2358

SECTION IV

Signature of person

Who is the subject of this request: _____Date:_____
State of Florida
County of_____
The foregoing instrument was acknowledged before me this _____day of_____20_____by_____

SIGNATURE_____

_____
(NAME OF NOTARY, TYPED, PRINTED OR STAMPED)

Personally Known_____ OR produced identification _____

Type of Identification Produce _____